Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MANDATORY MANAGED CARE

Changes in Medicaid Mental Health Services

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EXECUTIVE SUMMARY

PURPOSE

To provide an early look at the changes that mandatory managed care had on State Medicaid mental health services for persons with serious mental illnesses.

BACKGROUND

States are increasingly converting their Medicaid programs from traditional fee for service models to managed care models. Nearly every State has implemented, or is planning to implement, mandatory managed care for Medicaid beneficiaries who require mental health services. The increased use of this emerging form of care has generated interest within the Substance Abuse and Mental Health Services Administration and the Health Care Financing Administration, particularly care for persons with serious mental illnesses.

We used a case study approach for reviewing mandatory mental health managed care programs in seven States. We integrated, compared, and summarized documentary and testimonial evidence obtained from State Medicaid managed care offices and mental health departments. We also interviewed managed care organization officials, mental health providers and stakeholders. We did not validate the testimonial evidence, but we believe it provides a first hand view of this emerging form of care by program operators and stakeholders who have a strong interest in program effectiveness.

FINDINGS

Services Expanded

Managed care allowed States to offer more specialized and creative out-patient services. Further, States said overall use of mental health services increased. Four of 7 States documented increased utilization ranging from about one to 2 percent after conversion to a managed care system.

Costs Reduced

States converted to managed care primarily to reduce skyrocketing mental health costs. States reduced cost by setting limits for mental health costs in managed care contracts. They also achieved program savings by shifting care from in-patient to out-patient settings.

Stakeholders, however, expressed concern that lower average length of stays and increased readmission rates may indicate that persons with serious mental illnesses are being released from in-patient care too quickly.

Health Impact Not Quantified

No State had working outcome measures in place. Beneficiary satisfaction surveys and grievances may inaccurately reflect the level and quality of care received.

Savings Not Always Used to Improve Mental Health Services

Consistent with existing regulations, States returned "off the top" savings to the State's General Fund. States also used savings resulting from managed care operations to expand services to non-Medicaid eligible persons, and to help fund managed care administration. However, four States did not have the appropriate Medicaid waiver to use operational savings in this manner.

RECOMMENDATIONS

While States reported that managed care programs have expanded out-patient services, and reduced costs, the overall effect on the health of persons with serious mental illnesses was not quantified. However, resolution of several important concerns could significantly improve Medicaid mental health programs as more States convert to mandatory managed care. Accordingly, we recommend that:

- HCFA work with SAMHSA to develop outcome measurement systems that can be used as a condition of waiver approval.

- HCFA encourage States to establish independent, third-party mental health systems for conducting beneficiary satisfaction surveys.

- HCFA ensure that States obtain the required 1115 waiver before using savings from managed care operations to expand services to non-Medicaid populations.

AGENCY COMMENTS

Both HCFA and SAMHSA commented on our draft report.

HCFA disagreed with our draft recommendation to require States to develop outcome measures as a condition of waiver approval. While recognizing the importance of outcome measures, HCFA said no reliable and cost-effective outcome measurement system currently exists and that requiring States to develop such a system would stall the waiver process. We continue to believe that without an outcome measurement system States and HCFA have no way of determining the effectiveness of managed care services. However, based on HCFA comments we modified our draft recommendation to encourage HFCA and SAMHSA to work together to develop outcome measurements that can be used as a condition of waiver approval.

HCFA agreed that States need to improve systems for measuring and promoting beneficiary satisfaction, and that the neutrality of people involved in the complaint process is important. However, they disagreed with our recommendation to require the use of such third parties in State appeal and grievance systems. They noted that appeal and grievance systems were mandated in the Balanced Budget Act of 1997. We recently started an evaluation of these systems; therefore, we are holding in abeyance our draft recommendation until we complete the evaluation of State Medicaid managed care grievance and appeal systems.

HCFA disagreed with our recommendation that States have an approved 1115 waiver before using savings resulting from managed care operations to expand services to non-Medicaid populations. HCFA stated that no such waivers are required since States can use their own share of savings to provide additional services of any kind including services for non-Medicaid eligible persons. We agree with HCFA that States are free to use "off the top" State savings to fund services for non-Medicaid eligible persons. However, we are referring to savings within the managed care program itself, including the Federal share of these savings. Our understanding is that use of such savings for that purpose would require a 1115 waiver. We modified the text of our report to make this distinction clearer.

SAMHSA commented that a number of our recommendations were useful, but expressed concern about our drawing conclusions from what they believe is a study method that is not "scientific". We wish to emphasize that we used a case study method for our inspection. In describing our methodology we included a detailed explanation of the advantages and limitations of our case study approach. The limitations which we point out are similar to those described by SAMHSA. Our goal, however, was to take advantage of the early experience of some States to guide implementation of other States who are using a managed care approach for mental health services. We are confident that our readers will interpret our findings in the context of the methodology which we described. SAMHSA's thoughtful comments will also help our readers avoid the pitfalls of over generalization.

SAMHSA expressed concern about States offering mental health services under Medicaid managed care that are not authorized under traditional fee for service Medicaid. It was not the purpose of this study to determine if States were complying with Medicaid rules regarding allowable services. Rather, we were more interested in the general trends and practices of mental health services in a managed care environment.

Additionally, SAMHSA expressed concern that we may not have adequately included the views of State mental health staff and stakeholders. As shown in our methodology, we considered input from such groups as highly important. To illustrate, we interviewed at least 37 State mental health staff and stakeholders.

We also made several technical changes suggested by SAMHSA.

The full text of HCFA and SAMHSA comments are in Appendix B.